Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

UTMB AT GALVESTON
PO BOX 4786730
HOUSTON TX 77210

Respondent Name
GALVESTON COUNTY

Carrier's Austin Representative Box
Box Number 49

MFDR Tracking Number
M4-06-3149-01

MFDR Date Received
DECEMBER 9, 2005

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "This is trauma case & should be paid per fair and reasonable per DRG 486."

Amount in Dispute: $5,916.67

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary dated January 19, 2006: "Bill was paid in accordance with DWC Rule 134.401(c)(6) & (5). The diagnosis (primary) is trauma code. Therefore bill was paid per carrier methodology at a fair & reasonable rate."

Response Submitted by: Health Administration Services, P.O. Box 672447, Houston, TX 77267-2447

Respondent's Position Summary dated February 20, 2006: "The bill for this service was paid according to D.W.C. rule 134.401(c)(5) and (6). 'When the following ICD9 diagnosis codes are listed as the primary diagnosis, reimbursement for the entire admission shall be at a fair and reasonable rate. The primary diagnosis on the UB92 is 820.09 therefore the bill meets that criteria and was paid at a fair and reasonable rate. The bill was paid based upon the attached methodology which considers the scientifically based Medicare allowable for hospital reimbursement (APC payment) as well as contracts between Health Administration Services, T.P.A., and medical facilities in the Houston metropolitan area, also the daily reimbursement for inpatient stay."

Response Submitted by: Health Administration Services, P.O. Box 672447, Houston, TX 77267-2447

Respondent's Position Summary dated August 19, 2011: "We are in receipt of the attached August 10, 2011 notice regarding Dispute M4-06-3149. The Littleton Group now serves as the Third Party Administrator for the Galveston County who self insures their workers' compensation program." "I have enclosed the response filed by Health Administration Services, the prior TPA for the County, on February 20, 2006 in regards to the request for medical dispute resolution that was requested by UTMB at Galveston." "We have nothing further to add or supplement..."

Response Submitted by: The Littleton Group, 1250 S. Capital of Texas Hwy., Bldg 1, Suite 550, Austin, TX 78716-3627

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due

May 1, 2005 through May 18, 2005	Inpatient Services	$5,916.67	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.401 sets out the fee guideline for acute care inpatient hospital services.
3. 28 Texas Administrative Code §134.1 provides for fair and reasonable reimbursement of health care in the absence of an applicable fee guideline.
4. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.
5. This request for medical fee dispute resolution was received by the Division on December 9, 2005. Pursuant to 28 Texas Administrative Code §133.307(g)(3), effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, the Division notified the requestor on January 26, 2006 to send additional documentation relevant to the fee dispute as set forth in the rule.
6. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - M-No MAR.
   - G-Unbundling.
   - M-No maximum allowable reimbursement.
   - O-Denial after recon.

Findings

1. This dispute relates to inpatient surgical services provided in a hospital setting with reimbursement subject to the provisions of former 28 Texas Administrative Code §134.401(c)(5)(A), which requires that when "Trauma (ICD-9 codes 800.0-959.50)" diagnosis codes are listed as the primary diagnosis, reimbursement for the entire admission shall be at a fair and reasonable rate. Review of box 67 on the hospital bill finds that the principle diagnosis code is listed as 820.09. The Division therefore determines that this inpatient admission shall be reimbursed at a fair and reasonable rate pursuant to Division rule at 28 Texas Administrative Code §134.1 and Texas Labor Code §413.011(d).
2. Texas Administrative Code §134.1, effective May 16, 2002, 27 TexReg 4047, which requires that "Reimbursement for services not identified in an established fee guideline shall be reimbursed at fair and reasonable rates as described in the Texas Workers' Compensation Act, §413.011 until such period that specific fee guidelines are established by the commission."
3. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
4. 28 Texas Administrative Code §133.307(g)(3)(D), effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement." Review of the submitted documentation finds that:

   - The requestor's rationale for increased reimbursement from the *Table of Disputed Services* asserts that "This is trauma case & should be paid per fair and reasonable per DRG 486**.**"
   - While the Division has previously found that Medicare patients are of an equivalent standard of living to workers' compensation patients, (22 *Texas Register* 6284, July 4, 1997), Texas Labor Code §413.011(b) requires that "In determining the appropriate fees, the commissioner shall also develop one or more conversion factors or other payment adjustment factors taking into account economic indicators in health care and the requirements of Subsection (d). . . . This section does not adopt the Medicare fee schedule, and the commissioner may not adopt conversion factors or other payment adjustment factors based solely on those factors as developed by the federal Centers for Medicare and Medicaid Services." Therefore, a

reimbursement amount that is taken directly from the Medicare fee schedule or calculated based solely on conversion factors or other payment adjustment factors developed by the federal Centers for Medicare and Medicaid Services cannot be favorably considered when no other data or documentation was submitted to support that the amount paid is a fair and reasonable reimbursement for the services in dispute.

- The respondent did not discuss or explain how the amount paid represents a fair and reasonable reimbursement for the services in dispute.
- The respondent did not submit documentation to support that the amount paid is a fair and reasonable rate of reimbursement for the disputed services.
- The respondent did not explain how the amount paid satisfies the requirements of Division rule at 28 TAC §134.1.

The request for additional reimbursement is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under Division rules at 28 Texas Administrative Code §133.307. The Division further concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the services in dispute.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	11/12/2012 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.